New Albany-Floyd County Consolidated School Corporation
Health Services
2023-2024 School Year

Allergy and Anaphylaxis Emergency Action Plan

Attach child's photo

Child's name: _____ School: _____ Teacher: _____
Grade _____ Date of birth: ____/____/_____ Age _____ Weight: _____kg
Child has allergy to _____

Child has asthma.	Yes	No (If yes, higher chance severe reaction)
Child has had anaphylaxis.	Yes	No
Child may carry medicine.	Yes	No
Child may give him/herself medicine.	Yes	No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION:** If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine*
   - Inhaler/bronchodilator*

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine* (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine (see above)

Medicines/Doses

☐ Epinephrine, intramuscular (list type): _____ Dose: 0.15 mg 0.30 mg (wt > 25 kg)
☐ *Antihistamine, by mouth (med _____ dose_____frequency_____)
☐ *Other (inhaler, etc. med _____ dose_____frequency_____)

_____ _____ _____ _____
***Parent/Guardian Authorization Signature** **Date** **Physician/HCP Authorization Sign.** **Date**

_____ _____
***Parent/Guardian Printed Name** **Physician/HCP Printed Name**

Child's name: _____

Is student required to sit at a special table in the cafeteria and have a classroom that is designated free of the named allergen? Yes No

List allergens to avoid at table/classroom? _____

Additional Instructions/Information:

Contacts

Call 911

Doctor/HCP: _____ Phone: (____) _____-_____

Parent/Guardian: _____ Phone: (____) _____-_____

Parent/Guardian: _____ Phone: (____) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (____) _____-_____

Name/Relationship: _____ Phone: (____) _____-_____

***Please note:**

By signing page 1, I give permission to the school nurse and other trained personnel members to perform the tasks as outlined in the Allergy and Anaphylaxis Emergency Action Plan. I understand that a school nurse is not always present at my child's school and I give consent for other trained school personnel to provide care to my child as needed according to this plan. I give permission for the school nurse and prescribing health care provider to exchange information regarding any necessary medication order clarifications, response to medication, and adverse effects. I also consent to the release of information contained in this Allergy and Anaphylaxis Emergency Action Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. Unless other arrangements are made, I give the school permission to send home medication that has been in its possession with my child at the end of the school year.

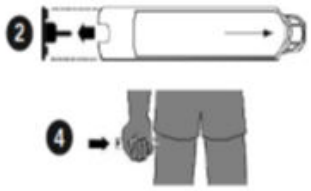
For School Personnel:

Please note:

- **NAFCS staff must accompany student on ambulance unless parent and/or emergency contact accompanies them.**
- **Document event and any medications given. Give used device to EMS.**
- **Ensure assistive personnel notifies ASC of 911 call made.**
- **If prescribed medical treatment is not available to school personnel, call EMS for any severe symptoms or combination of mild or severe symptoms from different body areas. Contact school nurse.**
- **Please ensure emergency medication is taken on all field trips.**
- **Be sure to share this information with any substitute teacher.**

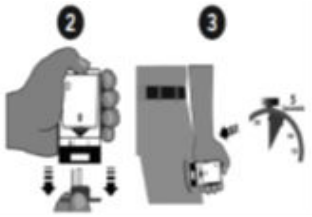
EpiPen/Epinephrine Auto Injector Directions

1. **Remove the autoinjector from the plastic carrying case.**
2. **IF a gray cap covers the orange tip, quickly twist it in the direction of "twist arrow" to remove.**
3. **Pull off blue safety release (Blue to the sky, orange to the thigh.)**
4. **While someone holds leg firmly in place, swing and firmly push orange tip against mid-outer thigh until it "clicks".**
5. **Hold firmly in place for 3 seconds.**
6. **Remove the autoinjector from the thigh and massage area for 10 seconds.**



Auvi-Q Auto Injector Directions

1. **Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.**
2. **Pull off red safety guard.**
3. **Place black end against mid-outer thigh.**
4. **Press firmly and hold for 2 seconds.**
5. **Remove from thigh and massage area for 10 seconds.**



Personnel who are trained including the date of training:	**Location of supplies:**
1. _____ Date _____ 2. _____ Date _____ 3. _____ Date _____ 4. _____ Date _____ 5. _____ Date _____ 6. _____ Date _____ 7. _____ Date _____ 8. _____ Date _____ 9. _____ Date _____ 10. _____ Date _____	☐ Health office ☐ With student_____ ☐ Classroom ☐ Specials classrooms ☐ Bus ☐ Other _____

This plan has been reviewed and approved by:	**Copies of HCAP given to/Date given:**
_____ School Nurse's Signature Date _____ Building Principal's Signature Date	Health Office _____ Teacher (Elem)_____ Principal_____ TOR (Sped) _____ Cafeteria_____ IEP(Sped) _____ ESC (Sped)_____ Bus/Aide_____ Transportation (if med in backpack for use on bus)_____ All trained staff_____